Supporting mental health in low-income communities: implications for justice and equity

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Abstract

This chapter examines the paradox between growing equity in mental health diagnosis and treatment and the discontent and injustice experienced by those living with poverty-related distress. The chapter identifies two inter-related ways in which forms of injustice impact upon people in low-income communities: first, examining how experiences of poverty and engagement with the welfare system can engender and exacerbate underlying vulnerabilities to mental distress; and second, focusing on the well-being implications of medicalising poverty-related distress. Particular attention is given to the relevance, effectiveness and ethics of current treatment options and their implications for equitable service provision and support.

Introduction

Mental health problems are currently viewed as constituting one of the greatest burdens on global health and wellbeing (WHO 2017). Recent years have witnessed a marked rise in mental health diagnoses and in the prescribing of mental health treatments across much of the economically developed world. Diagnosis for depressive disorders and anxiety disorders (common mental disorders) in particular, have shown a marked rise in recent years. Although depression can and does affect people from all backgrounds, the risk of becoming depressed is increased by poverty, unemployment and other challenging life circumstances (ibid).

Set against a broader background of austerity and on-going welfare reforms in countries such as the UK, the chapter explores the paradox between growing equity in access to mental health diagnosis and treatment and the high level of discontent and injustice being experienced by those living with poverty-related distress. Drawing on findings from DeStress (see http://destressproject.org.uk), a 2.5-year study in England, the chapter draws out two key, inter-related ways in which forms of injustice impact upon people in low-income communities: first, providing an overview of the

ways in which experiences of poverty and engagement with the welfare system can engender and exacerbate underlying vulnerabilities to mental distress; and second, focusing on the well-being implications of medicalising poverty-related distress. Particular attention is given to the relevance, effectiveness and ethics of current treatment options and their implications in terms of equitable service provision and support.

Mental health and treatment justice

The past decade has seen an unprecedented rise in the administration and use of pharmaceutical treatments for mental health. In Australia, antidepressants are now the most commonly used medications, being taken by 10% of the adult population at a rate that has more than doubled since 2000 (Davey and Chanen 2016). A similar picture can be seen in the USA, where there has also been a marked increase in long-term use of these medications (Mojtabai and Olfson 2014). In England, the number of antidepressant items prescribed more than doubled from 33.7 million in 2006 to 64.7 million in 2016 (NHS Digital 2017). Recent analyses demonstrate high levels of prescribing and use of psychoactive drugs in low-income communities (Anderson *et al.* 2009, Lewer *et al.* 2015, EXASOL 2017), with a parallel upsurge in the availability and promotion of talking therapies. Indeed, in England, where the government has committed strongly to the Improving Access to Psychological Therapies (IAPT) programme, over 900,000 patients a year had been seen by 2008, with plans to expand this to upward of 1.5 million a year by 2020 (Clark 2011).

One reading of these trends is that government provided mental health services have successfully challenged the inverse care law, by ensuring that widely recommended treatments are available to all who need them. In England, this stance appears to be backed up by an array of government policy committing to move toward parity of esteem between mental and physical health in terms of access to services, quality of care and allocation of resources (NHS 2015, Parkin and Powell 2017). This form of 'treatment justice' may be a sign that mental health stigma has decreased, and that more people now feel comfortable asking for help for depression and anxiety.

However, it may also be argued that these changes are part of an increasing trend towards the pathologisation of everyday stresses, a situation which in turn, incites stigma and medicalisation, and which absolves those with power from taking responsibility for the injustices caused by on-going economic, social and health inequalities.

Poverty, pathology and welfare

Much recent thinking around mental illness has been influenced by the dominance of medical guidelines such as the Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD), whose classifications and categories set boundaries on what should and should not be defined as 'normal' behaviour. Yet the authority of such guidelines, and in particular, the DSM V, have been widely criticised (see for example, Dowrick and Frances 2013) for expanding the boundaries of what counts as mental disorder so far, that emotions such as sadness and grief have become recast as forms of clinical depression.

In a situation where what would once have been considered unexceptional and expected reactions to common life stresses can lead to diagnosis with a mental health 'condition', it is important to consider how poverty and deprivation – known to constitute key factors in the creation and exacerbation of mental distress – intersect with psychiatric diagnosis and mental health treatment. This is particularly apposite in the context of economic austerity, where strategies to reform the system of welfare entitlement may impact on those aimed at supporting mental health and wellbeing, and where the chances of poverty-related distress being diagnosed and treated as mental *illness* are now extremely high.

If mental health diagnosis and treatment means that people experiencing mental ill health are receiving appropriate support, then this 'pathologisation of everything' (Conrad 2007) may rightly be seen as an important step forward for healthcare justice and parity. However, in situations where people's social identity and access to welfare support are increasingly and intrinsically connected to their health status and their ability to evidence sickness, this situation also raises a wide range of important ethical debates over the role that welfare reforms play in exacerbating distress, and the ways

that pathologisation and medicalisation intersect with poverty and disadvantage. This is turn, calls into question the relevance, effectiveness and even potential for harm, of the dominant treatment options that are being promoted under the auspices of supporting and enhancing people's mental health.

The pathological self

Associations between poverty and mental ill health are well established, with most explanations expounding a two-way process or a vicious cycle in which poverty may be seen to cause mental ill health, and mental ill health may be seen to lead to, or to exacerbate, poverty. Yet, whilst research on deprivation and mental health draws attention to the potentially distressing effects of living in poverty, there is little conclusive evidence about the nature of the relationship between the factors at play, nor what this might mean in terms of people's lived experience, or the appropriateness of mental health treatments available to them. A key issue here relates to the ways in which efforts to promote mental health, and much of the literature upon which this are based, remain focused at the level of the individual, meaning that mental health concerns become framed as a pathological problem of the 'self' (Busfield 2011). This has two major implications. First, a stance that is psychologically and behaviourally focused will inevitably reinforce a level of individualised blame and reiterate stereotypical assumptions about the behaviour of people living in deprived circumstances, leading to the re-inscription of deficits-based thinking that sees distressed people who are living in poverty as somehow deficient and in need of 'correction' through medical or therapeutic intervention. Second, by pathologising individuals as having a distinct and categorisable 'defects' within their brain or psychological functioning, mental health is viewed and treated in a disempowering apolitical vacuum, where the root causes of deprivation and social injustice that are known to sustain poverty and underpin the erosion of wellbeing become obscured (Shaw and Taplin 2007, Friedli 2013).

This is especially pertinent in the current economic climate, where notions of self and self-responsibility have been progressively amplified through neo-liberally oriented government policies to encourage the uptake of employment and to restrict access to welfare entitlements. For over three decades, successive British governments have

been claiming that the social security system has 'lost its way', and that large-scale reform is needed to abolish what George Osborne as Chancellor described as an entrenched 'something for nothing culture' (Blackburn 2013) in which people in receipt of benefits 'shamelessly' expect to be provided for whilst expecting others to go out to work.

As Walker (2014) has argued, this kind of vitriolic rhetoric has popular appeal, particularly in times of austerity and, by rendering 'welfare' as a term of abuse, has facilitated a range of reforms that have led to wide-scale reductions in welfare entitlements across the UK. Amongst other things, this includes a cap on the benefits available to an individual or household, the introduction of a controversial 'simplified' payment system through the roll-out of 'Universal Credit', and the imposition of the 'bedroom tax', whereby people living in social housing that is deemed to surpass their basic needs now have to pay for any 'spare' bedrooms within the property.

Importantly, these welfare reform strategies, as well as popular contemporary media, and encounters with key service providers such as Job Centres (see Friedli and Stearn 2015), are imbued with moralising narratives that promote the idea that individuals and households facing challenging circumstances should have been more 'responsible' in their actions to protect and enhance their health and wellbeing, and should have acted as 'good' and 'entrepreneurial' citizens (Crawford 2006, Ayo 2012) to maximise personal and societal interests whilst relieving the burden on the welfare system (Lupton 1995, Leichter 1997). Such thinking implies that those who are living in challenging or precarious circumstances have brought this upon themselves through irresponsible decision-making and actions. As a result, those in receipt of welfare support are now widely and publicly condemned as undeserving 'scroungers', unless they can provide convincing evidence that there are exceptional health circumstances that preclude them from employment. Indeed, recent research has found a hardening of attitudes against those in receipt of welfare support in the UK (NatCen 2013), as well as increased feelings of shame, stigma and disassociation within low-income communities themselves (Shildrick and MacDonald 2013).

Welfare and employment

Against this background, the DeStress project, which employed a range of qualitative methods (focus groups, interviews, conversation analysis of video-recorded GP-patient consultations), aimed to investigate the impacts of austerity and welfare reform on mental health in low-income communities; the relevance and effectiveness of current treatment options; and the challenges facing General Practitioners (GPs) working with low-income patients experiencing poverty-related distress.[i]

Far from constituting the 'easy option' that is so often portrayed within government rhetoric and popular media, findings from the project consistency emphasise the high levels of anxiety and stress that result not only from the challenges of poverty, but from engagement within the welfare system itself. The need to attend regular appointments (usually dependent on unreliable public transport), to provide sufficient evidence of job seeking (requiring access to computer and Internet) for limited and usually precarious work opportunities, to keep in line with the array of changes to benefits and associated rules that have been enforced in recent years, to deal with and challenge what many describe as frequent under- or delayed payments or benefits sanctions, to be shown to be 'bettering' yourself through voluntary work placements and to display the necessary 'work ready' psychology (see Friedli and Stearn 2015) to convince benefits advisors of your credibility were just some of the challenges that people felt added to the stresses of their lives.

Katherine[ii], for example, a full time volunteer worker at her local community centre was sanctioned in 2016 for missing a meeting after the Job Centre failed to alert her to a changed appointment time, meaning that she received no payments at all for eight weeks. Yet as her account makes clear, this was just one of her many experiences of missing or chasing up unpaid benefits,

> "I can spend hours and hours on the phone trying to sort the problem out so we actually will get paid. I mean, on average, out of a two month period at least three payments out of the four I will have to ring them up to chase my benefit payment so that we actually get the money […] I'm very lucky 'cos our daughter has a contract phone, which has minutes, so she will usually allow me to use her phone to ring…I haven't had any credit on my mobile for nearly two years, 'cos I just cannot afford to put credit on […] it gets me down, and after being on the

> phone for so long and having to go through it so many times, you know, I do get very, very disheartened with it. I know for a fact that, I mean, my husband with all his mental health problems and everything, I know, he couldn't do it. I know he couldn't do it. He couldn't cope with it. And there are a lot of people out there who can't because before now I have actually had people come up to me, where I volunteer, asking me to make these phone calls for them because they just can't cope with doing it, you know"

Welfare entitlement is also increasingly assessed via the possession of a legitimately certified 'disability', with previous health assessments no longer deemed as credible evidence to support existing claims. At face value, the underlying aim to 'encourage' people away from welfare and into employment is perhaps not in itself unreasonable, since there is ample evidence of the mental health-related benefits of work (Modini *et al.* 2016). Yet, recent years have witnessed increasing levels of poverty within working households in the UK (Tinson *et al.* 2016), with work-related stress and poor mental wellbeing being closely associated with the kinds of precarious and often low paid employment commonly available to those facing situations of hardship. Indeed, a recent report from Ireland (see Bobek *et al.* 2018) has shown clearly that precarious work is often associated with narrowly defined contracts and unpredictable hours, and can lead to a range of obstacles for people trying to establish families, or to secure loans, mortgages, or even to obtain rented accommodation. Furthermore, precarious work has been found to have negative impacts on both physical and mental health, which is in turn, particularly problematic when people have no recourse to sick leave. Thus whilst policies that encourage people to take up work may be empowering in some instances, evidence suggests they frequently push people towards situations that may ultimately reduce, rather than improve their quality of life.

Assessing the legitimacy of people's welfare claims also means that people living with chronic physical and/or mental health problems are now required to undergo more frequent medical assessments to decide their suitability for work. This procedure is undertaken by private companies that usually have no prior relationship with, nor insight into, the broader context and realities of an individual's life. For participants in the DeStress project who found themselves in this situation, the medical reassessment process was extremely traumatic and morally undermining,

especially when one's poor health status was questioned and de-legitimised during the assessment process. Participants in this situation explained how repeated medical assessment could greatly exacerbate mental distress, and lead to adverse economic repercussions when doubts about a person's claims resulted in their benefits being cut or withdrawn. Terry's case was typical of the kinds of stress and injustice caused by medical re-assessment.

> Terry (58) lives with his wife (50) in an economically deprived area of Plymouth. Despite being unable to read or write, Terry worked for around twenty years as a manual labourer and barman before being made redundant. Although he has since undertaken short bouts of work, his poor health means he has been unable to find secure employment during the past two decades. He explained that during this time, he has suffered from long bouts of depression and has multiple physical health issues that impede his breathing and heart functioning. In 2017, Terry received notice that he was required to attend a medical review procedure where, despite his age, health status and the support of his GP, he was reassessed as being 'fit for work'. At that point, Terry lost his right to Employment Support Allowance, leaving the couple to survive on £105 a week. From this, they pay all their bills, and are liable for a £25 a week 'bedroom tax' because the local authority has been unable to relocate them to a smaller property. Terry attends regular appointments with his GP where he gets sick notes that exempt him from having to evidence job seeking. However, this is a time limited 'solution' and the uncertainty of his situation and the couple's on-going poverty is a major cause of distress that intensifies their already poor health and wellbeing.

As Terry's case demonstrates, poverty and the demands of the welfare process can exacerbate vulnerabilities to intense distress and severe mental health issues within low-income communities. However, in a situation in which welfare requirements mean that poverty-related distress is increasingly medicalised, it is also important to consider whether the support available to people through mental health diagnosis and treatment necessarily acts to support equity or may, in cases, actually create injustice.

The medicalisation of distress

Research has shown that people in low-income communities face a range of socio-culturally determined issues that deter them from seeking formal help for mental distress (Clement *et al.* 2015). For some of the male participants in the DeStress study, this deterrent was associated with identity, pride and social status, with help seeking seen to engender shame and weakness. For others, there were more practical concerns relating to the logistics of travel and childcare, as well as a palpable fear amongst many parents who felt that asking for help for mental health and wellbeing-related issues would lead to their children being taken into the care of social services.

Despite the challenges people face in seeking support, it is clear from national prescribing data that many people from low-income communities *do* at some point in time turn to health professionals to seek support for mental distress (NHS Digital 2017). This may indicate that the person understands their distress through a medical framework, and accepts that they require some form of medically-focused treatment. However, in a situation in which large-scale and on-going resource cuts in the UK voluntary sector mean that General Practitioners (GPs) are often the only people left that people feel able to go to for help, and where GPs act as the main conduit for the administration of sick notes (now tellingly renamed 'fitness for work' notes) needed by people to evidence their ill health, the picture is often much more complex.

Whatever the situation, formal responses to mental health problems remain limited to two main forms of support and treatment: talking therapies and/or antidepressant medications. Whilst prescribing data imply that access to these treatments has improved in recent years, work carried out as part of the DeStress project, demonstrates how both options may in fact shape experiences of, and responses to mental health and wellbeing in ways that exacerbate rather than alleviate harm and injustice.

Talking therapies

In the past decade, considerable emphasis has been placed on the potential for non-medical interventions as a first line of support for people diagnosed with low-level depression and anxiety. Despite the Improving Access to Psychological Therapies

(IAPT) programme being widely heralded as a successful non-medical intervention, such services are currently delivered and evaluated through a 'one-size fits all' approach that disregards social and economic variation in need and provision in order to meet standardised targets around notions of 'improvement' and 'recovery', and aims to achieve this within the limits of six to eight sessions of group or individual counselling.

Central to this provision is a generally accepted requirement amongst health and service providers for people to self-refer to IAPT as a necessary 'first step to recovery'. Yet findings from DeStress indicate that a range of factors deter people from low-income groups self-referring for this kind of therapeutic support service. GPs interviewed and observed repeatedly emphasised the ease with which people could self-refer, and the need for patients to 'take responsibility' for themselves. However, almost all patients interviewed who had been referred to IAPT stressed the mental and logistical difficulties they faced doing this. Indeed, for some patients, the giving of the IAPT leaflet constituted a symbolic dismissal that undermined and delegitimised their concerns,

> "They gave me a self-referral thing to [local IAPT service] and like, okay, if I can't even pay my bills and I can't even like post a letter on time, then how am I going to, you know, do a self-referral to [local IAPT service]? [….] If you don't pay your water, you got no electric, no gas, how can you live? But you don't think about that when you're depressed - you're like if somebody else does it for you, you feel better, if somebody posts that letter for you or if somebody pays that bill - I mean I've got bills stacking up and stacking up, letters that I need to answer and it's just not that easy. So they go, "here, self-referral" and you're like no, that's why I need counselling to get out of this mess" (Delia)

> "It took me a lot to go to my doctor. And when I got there, on the first attempt, they gave me that leaflet. And I was just like, "I don't - I didn't come here for a leaflet. I came here for some help […] He just sent me away. It was like 'There you go, there's your leaflet, bye' " (Jonathan)

Alongside the challenges of self-referral, a reluctance to participate in what some saw as an unhelpful or even an indulgent process of self-reflection was clear. Amongst men in particular, there was an aversion to attending therapy when it was felt that it would focus on addressing their perceived mental pathology rather than help tackle the underlying poverty-related causes of their mental health problems. A common complaint amongst those who did attend IAPT, was that counsellors spent too much time focusing on stressful past events which they felt might explain a person's current mental state – or in cases, made unhelpful and often incorrect assumptions around childhood abuse, which both exacerbated people's upset and their distrust of the service, and failed to support what were often more practical stresses around issues such as debt and poor housing.

Perhaps the biggest issue of concern related to the stepped nature of IAPT support, and the difficulties people in low-income communities experienced accessing what they felt was a level of support appropriate to their needs. In one of the DeStress study sites where the IAPT service was formally assessed as 'failing' in meeting its 'recovery' targets, patients who had completed an initial assessment were then commonly refused access to the service because their needs were considered too high. This in turn, meant that they were referred back to their GP rather than on to more appropriate specialist care, resulting in patients left churning in the system, often for years, with no recourse to any further support.

Antidepressant medications

Recent analysis demonstrates disproportionately high levels of prescribing and use of psychiatric drugs within low-income communities (Anderson *et al.* 2009, EXASOL 2017). Whilst not disputing that these medications can be useful for some people, growing evidence now shows such drugs to have little or no effect in cases of mild depression, and that use of these medications can carry risks associated with harmful side effects, including increased suicidal thinking, and the potential for adverse interactions with other treatment drugs (Gøtzsche 2015).

Figures from a study in Scotland found that a third of all people taking antidepressants long-term had no clinical reason to continue with their treatment

(Cruickshank *et al.* 2008). Similarly, a number of DeStress study participants who had sought support from their GP had been surprised to find themselves being prescribed with antidepressants, and felt disappointed that this was the only support available to them. A frequently repeated concern was the readiness with which antidepressants were prescribed, and the lack of information they perceived they had been given on the likely side effects of the medications. Whilst the DeStress data suggest that decisions over treatment are often reached as part of a process of negotiation between GP and patient, there was also evidence to suggest that patients were sometimes prescribed antidepressants despite having stated that this went against their wishes. In some interviews, patients revealed that they 'cashed in' their prescription and got their medications in order to be seen to be obeying the advice of the GP, but they did not then take them. Participants also identified a lack of information or support to help them to stop taking the medications safely, and it was not uncommon for people to recount their painful experiences of going 'cold turkey' with no advice on how best to manage this.

Findings from DeStress also suggest the paradoxically problematic nature of both poor adherence and long-term antidepressant use within low-income communities. Research in the UK shows that half of all people on antidepressants have been taking them for two years or more (Kendrick *et al.* 2015), a figure that is almost certainly much higher amongst low-income populations. An increasing body of evidence suggests that rather than treating mental ill health, the long term use of antidepressants can actually be significantly detrimental to mental health and wellbeing – and that in many cases, long-term use of psychiatric medicines not only exacerbates existing mental health conditions, but may also trigger new ones. Data from a recently published twenty year longitudinal study, for example, show that at each follow-up assessment, people who had taken antipsychotic drugs were significantly more likely to display psychotic symptoms that those who had never taken medications (Harrow *et al.* 2014). Other research suggests that antidepressants not only have limited effectiveness over placebos but may also affect people's vulnerability to depression in their future lives (Kirsch *et al.* 2008).

Originally intending to sample people with a mental health diagnosis within the previous two years, it quickly became clear that for most people in the DeStress study

sites, antidepressant use had been on-going across episodes of distress that had persisted for a long time. Gillian's case illustrated this clearly.

> Gillian (26) has been taking anti-depressant medications on and off for long periods of time over the past decade. Having grown up within a violent household, she left home before completing school, and found herself living with an abusive partner with whom she had her first child. Fearing that her child would be taken away if she approached social services for assistance, she sought help from her GP, who diagnosed her with post-natal depression. She received the same diagnosis after the birth of her following two children. Gillian recognises that many of her negative thoughts stem from her past experiences, and from the on-going challenges of living on a very low-income. Although she feels that the medications help her to cope with life, she feels that there has been little opportunity to try or even to discuss other options for support. The last time she remembers anyone suggesting alternatives to medications was four years ago, and this was never followed up. While she recognises that GPs have few options available to them to help people experiencing poverty-related distress, she feels strongly that there is an inclination amongst service providers towards 'upping the dose' rather than addressing the wider social issues that people experience.

For Gillian, as for others, antidepressants helped her cope with daily life, yet they did not help to solve the underlying causes of the distress and, for a large proportion of interviewees, their use left them feeling numb and disengaged from those around them. In a situation in which GPs are encouraged by clinical guidelines to reassess treatment decisions only when side effects are palpably detrimental to patient health; when health providers are massively constrained by cuts to resourcing; and when people may assume that they are expected to continue treatment unless otherwise advised, the likelihood of people remaining on antidepressants in the long term becomes increasingly apparent. There is therefore, an urgent need for health providers to reassess existing practice with respect to antidepressant prescribing in the UK, both to ensure that medications are being prescribed appropriately and to guarantee that their use is monitored and regularly assessed in light of changing patient

circumstances. Failure to do this is not only costly and wasteful in terms of resourcing but is morally and ethically dubious.

Conclusions

Recent years have seen a commitment amongst policy makers in England to increasing parity of esteem between mental and physical healthcare and to make mental health treatment more available to all in need. Yet, as this chapter has argued, there has been inadequate critique of the diagnostic assumptions that underpin the evidence upon which such data and such strategies are based, as well as a lack of consideration of the broader economic and political circumstance in which forms of treatment 'justice' are being administered. This becomes deeply problematic when the distress naturally caused by the challenges of poverty and deprivation is increasingly interpreted as clinical depression requiring medical intervention. Indeed, very real questions around justice are brought to the fore when moralising and stigmatising strategies designed to reform the system of welfare support overlap with and impact on those aimed at supporting mental health and wellbeing.

Far from supporting those most in need, we have shown that the increasingly punitive nature of current welfare reform exacerbates underlying vulnerabilities to mental distress for many people through the wide-scale reduction of benefit entitlement, the questioning and de-legitimisation of people's medical or disability status and the dehumanising experience and repercussions of dealing with 'the system' itself. At the same time, current treatment options have been shown to have a range of adverse impacts on health and wellbeing that call claims around treatment justice into question. The use of antidepressant medications can numb the realities of poverty and can help enable people to cope with daily life in austerity Britain – yet for many participants in the DeStress study, their use has led to the long-term use of what are often stigmatised, potentially ineffective and even harmful medications, with what patients feel has been little opportunity for review. For others, the offer of 'therapy' to 'improve' or 'recover' an individual's pathology and their ability to cope can prove unhelpful and upsetting when it fails to address the broader social circumstances which fuel the person's underlying distress.

This is certainly not to point a finger of blame at General Practitioners (GPs), who in the UK are increasingly working in severely resource constrained environments with few options to provide other forms of support to those experiencing poverty-related mental distress. Indeed, almost all of the GPs interviewed as part of the DeStress project expressed anger and frustration at the way that they had become caught up in current and previous Government drives to cut costs through slashing welfare entitlements and deliver what David Cameron as Prime Minister called 'a responsible society'. Rather it is to recognise that whilst the delivery of wide-scale mental health treatment must be applauded in circumstances where it genuinely and effectively responds to need, its current entanglement with wider political agendas has resulted in the pathologisation and medicalisation of what are inherently social and structural issues, and that this in turn can increase stigma, blame and injustice against those in low-income communities.

At the heart of these issues are questions about where responsibility for health and wellbeing should lie. Governments can facilitate responsibility in citizens when they provide the material and structural resources required for this to become feasible. Yet, within the current neo-liberally oriented era, government and popular rhetoric around individual responsibility feed directly into strategies aimed at reducing welfare support, blaming and shaming individuals and communities, and deflecting attention from the responsibilities of those with the power and remit to effect positive change. Such a situation is clearly inequitable and in fact damaging to people's mental health and wellbeing.

Whilst solutions to this situation ultimately require a fundamental shift in the culture and language of policy and practice, more immediate - and ultimately cost-effective, strategies do exist that may help alleviate, and more effectively respond to, distress within low-income communities. As part of DeStress, we are for example, working with Health Education England, health practitioners and low-income communities to develop training materials for GPs on how to use the limited time available within consultations to more effectively engage with people experiencing poverty related distress. A key aspect of this work involves enabling GPs to feel better able to play a supportive and empathic role that encourages patients to reflect on their situation and

identify positive ways forward, rather than feeling that they necessarily need to 'fix' patients through diagnosis and treatment.

There is also strong evidence from DeStress that a great deal of distress within low-income communities is caused or exacerbated by social isolation and stigma. Where local community groups (often informal in nature) exist, they have been shown to act as powerful support mechanisms that give people reassurance and a sense of purpose and belonging. Successive UK governments have reduced funding for these activities – yet reinstating and bolstering funding for these kinds of groups would undoubtedly contribute to better wellbeing and more just outcomes.

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[i] The DeStress study took place in two study sites within South West England.
[ii] To protect their anonymity, all participant names used in this chapter are pseudonyms.